USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200
Fax (501) 399-3806

# Proof of Death

For H.O. Use Only
Eff _____
PTD _____
Benefits _____

## DEATH OF AN INSURED EMPLOYEE

**Important: Read Carefully**

**WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison**.

**This form is to be completed upon the death of an insured and forwarded to USAble Life. In addition, an official Certified Death Certificate is required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, USAble Life shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.**

## EMPLOYER'S STATEMENT

| | | |
|---|---|---|
| USAble Life's Group Number | Certificate/ID Number | |
| Name of Employee | Date of Birth | Date of Death |
| Address | City, State, Zip | |
| Date Employed | Date on which employee was last "actively at work" | |

Reason Employee stopped work ☐ Death ☐ Disability ☐ Retirement ☐ Termination of Employment

Date on which employment terminated _____

Claim is for (check all applicable)

☐ Basic Group Term Life Amount $ _____ ☐ Accidental Death Amount $ _____

☐ Supplemental/Vol. Group Term Life Amount $ _____ ☐ Optional SeatBelt Rider (if applicable) Amount $ _____

1. Did the deceased die in a motor vehicle accident? ☐ Yes ☐ No
   If yes, was the deceased wearing a seat belt? ☐ Yes ☐ No
2. Do you recommend payment of this claim? ☐ Yes ☐ No

| | | |
|---|---|---|
| Employer | Fax Number ( ) | |
| Signature | Title | Date |
| Name (Please Print or Type) | Telephone ( ) | |
| Address | City, State, Zip | |

## AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of the deceased or his health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

Date _____ Signature of Nearest Relative _____ Relationship To Deceased _____

## BENEFICIARY'S STATEMENT

I certify that the information furnished in support of this claim is true and correct.

Beneficiary's Name (Please print) _____ Relationship To Deceased _____

Beneficiary's Date of Birth _____ Beneficiary's Social Security # _____ Daytime Telephone _____

Address _____ City, State, Zip _____

Date _____ Beneficiary Signature _____



**(See Page 2/reverse side for death of an insured dependent.)**

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## DEATH OF AN INSURED DEPENDENT

**Important: Read Carefully**

**WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison**.

**This form is to be completed upon the death of an insured and forwarded to USAble Life. In addition, an official Certified Death Certificate is required. If death was due to suicide, homicide or accidental means, a copy of the investigating officer's report is also required. By furnishing this form and investigating the claim, USAble Life shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.**

## EMPLOYER'S STATEMENT

| USAble Life's Group Number | Certificate/ID Number | Date of Death |
|---|---|---|
| Name of Employee | Name of Deceased Dependent | |

Claim is for (check all applicable)

☐ Basic Group Term Life Amount $ _____ ☐ Accidental Death Amount $ _____
☐ Supplemental/Vol. Group Term Life Amount $ _____ ☐ Optional SeatBelt Rider (if applicable) Amount $ _____

1. Did the deceased die in a motor vehicle accident? ☐ Yes ☐ No
   If yes, was the deceased wearing a seat belt? ☐ Yes ☐ No
2. Do you recommend payment of this claim? ☐ Yes ☐ No

| Employer | Fax Number ( ) | |
|---|---|---|
| Signature | Title | Date |
| Name (Please print or type) | Telephone ( ) | |
| Address | City, State, Zip | |

## EMPLOYEE'S STATEMENT

| Deceased's Relationship to Employee | Deceased's Date of Birth |
|---|---|

If relationship is shown to be "child," was deceased married at the time of death? ☐ Yes ☐ No

If relationship is shown to be "spouse," was deceased divorced or legally separated from you? ☐ Yes ☐ No

Was the deceased a dependent and used by you as such for income tax purposes? ☐ Yes ☐ No

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of the deceased or his health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

Date _____ Employee's Signature _____ Employee's Social Security # _____

Address _____ City, State, Zip _____ Daytime Telephone _____

**(See Page 1/reverse side for death of an insured employee.)**